DMV-14- **West Virginia Division of Motor Vehicles** 4/98
TR-WEB **Application for Parking for Person with a Disability**

SECTION 1: APPLICANT INFORMATION	Please print in ink or type all of the following information:

Name Last	First	Middle	Social Security Number

Mailing Address	City	State	Zip Code

Date of Birth	Sex	Indicate type of permit desired: ☐ Plate ☐ Placard

Lost/stolen plate number	Lost/stolen placard number	If requesting a plate or placard duplicate, please indicate if the original was: ☐ Lost ☐ Stolen

The line of information below is only required if requesting a license plate.

Title Number	Make	Year	Weight	Current License Plate	Vehicle Identification Number

I certify that I am a person with a disability which limits or impairs my ability to walk. I understand that any false statement may result in legal penalties pursuant to West Virginia Motor Vehicle Law §17C-13-6. A parent or legal guardian may sign for the applicant if the applicant is unable to do so. Please note your relationship to the applicant.

Signature of Applicant or Parent/Legal Guardian	Date

SECTION 2: PHYSICIAN'S CERTIFICATION

I certify that the above described applicant is a patient of mine and in my professional opinion his/her ability to walk is limited or impaired based on one of the following reasons as outlined in 23 CFR 1235.2(b) 1-6:

☐ **Permanent (2 year exp.)** ☐ **Temporary (1 to 3 months)** ☐ **Temporary (4 to 6 months)**

☐ Cannot Walk 200 feet without stopping to rest

☐ Cannot Walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair or other assistive device

☐ Is restricted by lung disease to such an extent that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60mm/hg on room air at rest

☐ Uses portable oxygen

☐ Has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III of Class IV according to standards set by the American Heart Association

☐ Are severely limited in their ability to walk due to an arthritic, neurological or orthopedic condition

Note: **Please fill out this entire section. Failure to do so will result in this form being returned to the sender for completion. All physicians' signatures and medical licenses are subject to review and verification. Physicians may be required to submit further documentation to substantiate the disability.**

Physician's Name (Please print in ink or type)	Medical License Number	Medical License Expiration Date	
Business Address	City	State	Zip Code
Signature	Date	Telephone Number	

FOR DMV USE ONLY

Issued By	Issue Date	Expiration Date	☐ Lost ☐ Stolen

Placard\Plate Number	Previous Placard\Plate Number

If you have any questions concerning fees or requirements, please read our instruction page.